AGING AND DISABILITY SERVICES ADMINISTRATION
OMNIBUS BUDGET RECONCILIATION ACT (OBRA)
NURSING ASSISTANT TRAINING PROGRAM
PO BOX 45600
OLYMPIA WA 98504-5600

DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION
PO BOX 47864
OLYMPIA WA 98504-7864

APPLICATION FOR NURSING ASSISTANT TRAINING PROGRAM APPROVAL (NATCEP)

DATE OF APPLICATION

LEGAL NAME OF SPONSORING HEALTH CARE FACILITY, HOSPITAL, SCHOOL OR OTHER ENTITY	TELEPHONE NUMBER (INCLUDE AREA CODE) ( )

MAILING ADDRESS	CITY	COUNTY	STATE	ZIP CODE

STREET ADDRESS IF DIFFERENT FROM MAILING ADDRESS	CITY	STATE	ZIP CODE	E-MAIL ADDRESS

NAME OF FACILITY ADMINISTRATOR, VOCATIONAL DIRECTOR, DEPARTMENT HEAD, OR CHIEF ADMINISTRATIVE OFFICER

NAME OF PROGRAM DIRECTOR, NURSING ASSISTANT TRAINING PROGRAM	CONTACT TELEPHONE NUMBER (INCLUDE AREA CODE ( )

Describe the classroom space allotted to your training program. Specify type of room, square footage, self-contained or shared space, room equipment and classroom furniture, square footage, maximum number of students that can be comfortably accommodated, other uses of this room during non-class time and the availability/location of teaching materials and audio-visual equipment. Attach a separate sheet if necessary. Is this classroom off-site, that is, located elsewhere from the street address listed above? ☐ Yes ☐ No

Describe the training laboratory and the personal care equipment used for the practice of clinical skills. Attach a separate sheet if necessary.

Will the student go off-site for any clinical training? ☐ Yes ☐ No If yes, list the name(s) of these clinical training sites.

List the teaching resources for the program. For example, name and publication date of textbooks and audio-visual equipment.

Textbooks:

Audio-visuals:

Other (specify):

Number of hours proposed for your Nursing Assistant Training Program: Classroom _____ Clinical _____ Total Hours: _____

Important: Please read Page 2 of this form.

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Branch Training Location

Will this training program offer or sponsor Nursing Assistant Training (classroom) at one or more locations other than the program's address listed on Page 1? ☐ Yes ☐ No

If answered "yes", please complete and attach one 14-371B, Branch Training Location form for each branch location proposed.

The following attachments are required for all programs. ATTACH THE FOLLOWING TO THIS APPLICATION.

☐ 1. Application for Nursing Assistant Program Director (NATCEP), DSHS 14-370

☐ 2. Declaration of the Program Director (NATCEP), DSHS 09-961

☐ 3. **Instructional Staff Applications, DSHS 14-369.** This is not applicable if the program director is the sole instructor.

☐ 4. A list of **course objectives** for your training program.

☐ 5. The **curriculum outline and schedule of class and clinical presentations**. The applicant must provide evidence of content that will lead to the achievement of all required nursing assistant competencies listed in Washington Administrative Code (WAC) 246-841 and 42CFR 483-152.

☐ 6. A **sample lesson plan** for one core unit of the curriculum outline. This includes a lesson plan objective and any supporting sub-objectives.

☐ 7. The **skills checklist** used in your program for skills achievement verification.

☐ 8. A **description of the evaluation methods** and your program requirements for passing. Describe below or use a separate sheet.

☐ 9. Copies of the required affiliated agreement with facilities where clinical training is conducted. (Non-facility based programs only)

☐ 10. Sample of student record form to be used by training program. If program is not in a long term care facility, attach all agreements for clinical training.

☐ 11. If applicable, Branch Training Location form completed and submitted. (DSHS 14-371B).